MaineCare Services
An Office of the
Department of Health and Human Services

MaineCare

Behavioral Health Homes RFA Information Session

October 29, 2013

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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Overview

- A <u>new service</u> being offered by MaineCare in April, 2014

- Per the Affordable Care Act, a Health Home offers:
  - Care Management of physical and mental health needs
  - Care Coordination and health promotion
  - Help in transitional care, including follow up
  - Support to help self-manage physical and mental health conditions
  - Referral to other services
  - The use of Health Information Technology to link services

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Maine's Health Homes "Stage A"

Primary Care

Community Care Teams (CCTs)

Health Homes

Serves adults and children with chronic health conditions

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Maine's Behavioral Health Homes – "Stage B"

Licensed Community Mental Health Provider

A Primary Care Practice

Behavioral Health Homes

Serves adults and children with significant behavioral health needs

Key Features

- Integrated across behavioral and physical health
- Team-based, comprehensive approach:
  - nurse care manager
  - peer support specialist
  - licensed clinical social worker
  - health home coordinator
- Data-supported
- Outcomes-oriented

Eligibility

- Adults with Serious Mental Illness
- Children with Serious Emotional Disturbance

This initiative closely aligns with current eligibility for community mental health services. People eligible for the following services will also generally be eligible for Behavioral Health Homes:

  - Adults: Community Support Services
  - Children: Targeted Case Management

Member Choice

- Services currently received through targeted case management or community integration will be received through the BHH
- Certain other services will be considered a duplication; members can choose which service they would like to receive
- Members will choose a PCP that partners with their behavioral health home organization
- Members can stay with their current services, or join the BHH.
- People can opt out of the service at any time

Application Requirements: BHHO

License to provide Mental Health Community Support Services:

- BHHOs that serve adults must be able to meet all consent decree requirements as described in Riders A and E of the DHHS adult mental health services contract
- BHHOs that serve children must comply with Rider a and E of the DHHS children's services contracts
- Expertise in co-occurring disorders pursuant to DHHS contract standards

Must deliver or have MOA with psychiatric medication management provider to provide consultation services to the BHHO team and partnering PCPs as needed

Application Requirements: BHHO

Commitment to adoption of and implementation of an electronic health record within 24 months of BHHO implementation:

- State Innovation Model resources and BH EHR Request for Proposals will prioritize community BHHO providers
- MaineCare will specify key benchmarks for EHR development

Application Requirements: BHHO

Commitment to implementation of Core BHH expectations:

- Demonstrated Leadership
- Team-based approach to care
- Enhanced access to care
- Population risk stratification and management
- Comprehensive consumer/family directed care planning
- Inclusion of patients & families in implementation of BHH model
- Behavioral-Physical Health Integration
- Connection to community resources and social support services
- Commitment to reducing waste and unnecessary health care spending
- Integration of Health Information technology

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Application Requirements: BHHO

Ability to provide each of the following BHH services (from federal guidance):

Provide quality driven, cost-effective, culturally appropriate, and patient- and family- centered Health Home services;

Coordinate and provide access to high-quality health care services informed by evidence based clinical practice guidelines;

Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;

Coordinate and provide access to treatment for mental health and substance abuse disorders;

Coordinate and provide access to comprehensive care management, care coordination, and transitional care across care settings. Transitional includes appropriate follow up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from pediatric to an adult system of health care;

Coordinate and provide access to chronic disease management, including self-management support to patients and their families;

Coordinate and provide access to patient and family supports, including referral to community-based social support, and recovery services;

Coordinate and provide access to long-term care supports and services;

Develop a patient-centered care plan that coordinates and integrates all of a patient's clinical data and non-clinical health care related needs and services;

Demonstrate the capacity to use Health Information technology to link services, and facilitate communication among members, and between the BHHO and member , and family members as appropriate, and to provide feedback to practices, as feasible and appropriate; and

Establish a continuous quality improvement (CQI) program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality care outcomes at the population level.

Application Requirements: BHHO

Participate in the Behavioral Health Home Learning Collaborative:

- Learning collaborative activities focused on technical assistance and support in achieving Core Expectations
- Providers will need to identify a leadership team (clinical and administrative leadership)
- Participate in learning collaborative activities (at least 4/per year)

Application Requirements: BHHO

- Partnership with at least one Health Home Practice
  - As of implementation date, BHHO must have at least one formalized partnership with a HHP.
  - MOA between BHHO and HHP should include organizations' collaboration/coordination strategy, such as :
    - Names and contact information of key staff at BHHO and HHP
    - Procedures for effective communication, e.g.:
      - Acceptable mode(s) of electronic communication to ensure effective and privacy-protected exchange of health information
      - Frequency of communication at both leadership and practice levels (e.g., weekly, monthly, quarterly)
      - Procedures for bi-directional access to member plan of care and other health information
      - Referral protocols for new members
      - Method for collaboration on treatment plans and member goals
      - Business Associate Agreement/Qualified Service Organization addenda.

Application Requirements: BHHO

Ability to deliver team-based care, including:

- Clinical Team Leader
  - independently licensed mental health professional, including an Licensed Clinical Social Worker, Licensed Clinical Professional Counselor, Licensed Marriage and Family Therapist, psychologist, psychiatrist
- Health Home Coordinator
  - Qualified TCM case management providers for children and Mental Health Rehabilitation Technician/C certified providers for adults
- Peer Support Specialist
  - Certified Intentional Support Specialist and/or other training as may be described by the Department
- Nurse Care Manager
  - (Licensed Practical Nurse, Registered Nurse, Nurse Practitioner)
- Primary Care Consultation
- Psychiatric Consultation

Health Home Practice Requirements

Primary care providers must:

- Complete a Health Home primary care practice application and be approved by MaineCare
- Have implemented an Electronic Health Record (EHR) system.
- Provide Twenty-Four Hour Coverage, as defined in MaineCare Benefits Manual, Ch. VI - Section 1: Primary Care Case Management.
- Have received National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home recognition by date determined by MaineCare
- Have established member referral protocols with area hospitals, which include coordination and communication on enrolled or potentially eligible HHP members.
- Must partner with a community mental health provider that is approved to deliver Behavioral Health Home services.
- Commit to Core Expectations for Health Home practices

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Reimbursement

Payment is structured to support both the PCP and the community mental health provider to coordinate care:

Primary Care practice	$15/PMPM
Behavioral Health Organization	$290.00/PMPM for children $330.00/PMPM adults

Mainecare is also proposing to CMS an additional $35.00 PMPM during the first six months of start up for additional engagement, education, and outreach

Staffing Assumptions

Staff	FTE per 200 members
Clinical Team Leader	0.75
HH Coordinator	7 (children) 8 (Adults)
Peer Specialist	1
Nurse Care Manager	Child: 0.50 Adult: .75
Medical Consultant	0.02
Psychiatrist	0.02

Rate methodology also includes 30% fringe and 30% administrative overhead

Service expectations

- Minimum billable service is one hour per member, per month for the Behavioral Health Home organization
- Services can be delivered by any member of the team and may be in person, by phone, in a group setting
- Team meetings and collateral contacts included
- Health promotion and wellness activities
- Providers serve and bill for all eligible members, not only members that are seen in person
- Six month review/continuing stay criteria TBD

Next Steps

Milestone	Date
Notice of Intent	Friday, November 15, 2013
Summary of Q&A	Friday, November 15, 2013
Applications Due	December 6, 2013
Provider Approval/Commitment Letter	January 10, 2014
Notice to Members	March 3, 2014
Implementation	April 1, 2014

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More information

MaineCare's Value-Based Purchasing Website:

http://www.maine.gov/dhhs/oms/vbp/

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